SUPREME COURT, U.S.
FILED
JAN - 4 2016
OFFICE OF THE CLERK

No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, *et al.*,

Petitioners,

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICI CURIAE* MEDICAL STAFF PROFESSIONALS IN SUPPORT OF PETITIONERS

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Robinson v. UGHS Dallas Hospitals, Inc.,
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STATUTES AND REGULATIONS

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SUP. CT. R. 37.6 1

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OTHER AUTHORITIES

Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members*, 36 J. Health L. 247.....26

Cited Authorities

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Hugh Greeley, *The Greeley Guide to Medical Staff Credentialing* (1999). . . . . *passim*

Joint Commission, *Comprehensive Accreditation Manual for Hospitals 2015 Update 2* (effective Jan. 1, 2016) . . . . . *passim*

Joint Commission, *FAQ "Using Data from Outside Organizations to Accomplish the Ongoing Professional Practice Evaluation/Low Volume Practitioners"* (last updated March 23, 2010) . . 34-35

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John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 Am. J.L. & Med. 173 (1996) 12

Robin Locke Nagele, et al., *Economic Credentialing* (2004) 25, 26, 27

Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013) 9

United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (5th ed. 2009) 29

Nancy Auer, Jeffrey Borkan, Jonathan Burroughs, Carol Cairns, William Cors, David Dodge, Hugh Greeley, Seth Guterman, Kathryn Meyer, Vicki Noble, Linda Riggs, Todd Sagin, Vicki Searcy, Mark Smith, Michael Stauder, Richard Thompson, Susan Toth, Gregory Volturo, and Abigail Winkel ("*Amici*" or "Medical Staff Professionals") submit this brief in support of Petitioners Whole Woman's Health; Austin Women's Health Center; Killeen Women's Health Center; Nova Health Systems D/B/A Reproductive Services; Sherwood C. Lynn, Jr., M.D.; Pamela J. Richter, D.O.; and Lendol L. Davis, M.D.

INTEREST OF AMICI CURIAE[1]

Amici curiae are healthcare practitioners, professors, managers, and consultants. They teach and practice at some of the country's top medical schools and hospitals, they serve on credentialing committees, and they have acted as hospital trustees and chief medical officers. *Amici* submit this brief to provide the Court with a correct understanding of how admitting privileges are granted and why they present a significant obstacle to the practice of abortion providers. Specifically, laws requiring local admitting privileges impose requirements on outpatient abortion providers that, by the very nature of their practice, they are unable to meet.

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1. Pursuant to SUP. CT. R. 37.3(a), *Amici* certify that both parties have consented to the filing of this amicus brief. Pursuant to SUP. CT. R. 37.6, *Amici* certify that no counsel for any party authored this brief in whole or in part, no party or party's counsel made a monetary contribution to fund its preparation or submission, and no person other than *Amici* or their counsel made such a monetary contribution.

Amici are health care professionals with varied and substantial experience with the process of credentialing and privileging of physicians:

Nancy J. Auer, M.D., is a retired emergency physician who served as Director of Emergency Services, Chief of Medical Staff, Vice President of Medical Affairs (VPMA), and Chief Medical Officer (CMO) for Swedish Health Systems, Seattle, Washington. In her role as Chief of Medical Staff, VPMA and CMO, Dr. Auer oversaw medical staff credentialing. Dr. Auer is Immediate Past Chair of the Board of Trustees of Swedish and serves on the Medical Affairs Committee of the Board, which oversees credentialing of the medical staffs of Swedish's five hospitals.

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Carol Cairns, CPMSM, CPCS, is a medical service manager who coordinated and directed medical staff services for Presence Saint Joseph Medical Center and Silver Cross Hospital in Illinois, serving on the Bylaws and Credentialing Committee. In 1996, Ms. Cairns founded PRO-CON, a consulting firm specializing in credentialing, privileging, medical staff organization operations, and survey preparation. Ms. Cairns has written all six editions of *Verify and Comply: A Quick Reference Guide to Credentialing Standards*, the third and fifth editions of *Core Privileges: A Practical Approach to Development and Implementation*, and *The Medical Staff's Guide to Overcoming Competence Assessment Challenges.*

Dr. William Cors, M.D., MMM, FACPE, is an experienced physician executive with 15 years of clinical practice and 20 years of executive hospital/health system management. He currently serves as Chief Medical Officer for Pocono Health System in Pennsylvania. His primary areas of expertise include strategic alignment of medical staff and hospital leadership and governance; credentialing, privileging and peer review; and improvement of quality of care and patient safety. Dr. Cors served on the Board of Directors of the American College of Physician Executives from April 2007 to March 2010.

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Hugh Greeley began his health care career in 1973 while working with the National Blue Cross Association and then with the Joint Commission on Accreditation of Hospitals in Chicago, Illinois. Since that time Mr. Greeley has worked with medical societies, hospital associations, universities and foreign governments, and is widely regarded as an expert in medical staff administration, hospital governance, credentialing, performance improvement, accreditation, antitrust and corporate negligence. Mr. Greeley is also on the faculty of the Governance Institute, La Jolla, California, and a former member of The Bureau of the Healthcare Facilities Accreditation Program, Chicago, Illinois.

Seth Guterman, M.D., FACEP, is an emergency physician who currently serves as President of Emergency Care Physicians Services, President at People's Choice Hospital in Chicago, President of Empower Systems, and Department Chairman and Physician practicing Emergency Medicine in Blue Island, Illinois. He is board certified in emergency medicine, and he has published and lectured on emergency medicine and accreditation issues in the emergency department.

Kathryn Meyer, J.D., served as in-house counsel for several New York City hospitals from 1975 to 2011, and for eight years as Executive Vice President and General Counsel of Continuum Health Partners. As counsel, Ms. Meyer advised hospitals' credentials committees and

medical staff regarding handling of physician applications, and drafted medical staff bylaws. Ms. Meyer also served on the Board of Directors of the American Academy of Hospital Attorneys, chaired the Association of the Bar of the City of New York's Committee on Health Law, and authored a chapter on medical staff credentialing for *Health Care Law: A Practical Guide* published by Matthew Bender.

Vicki Noble, M.D., is a physician in the Department of Emergency Medicine and Director of Emergency Ultrasound at Massachusetts General Hospital and is an Associate Professor at Harvard Medical School. Dr. Noble is responsible for point of care ultrasound privileging for the hospital.

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Mark Smith, M.D., M.B.A., FACS, is a consultant with HG Healthcare Consultants with expertise in peer review, ongoing and focused professional practice evaluation, management of deficient practitioner performance,

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Richard E. Thompson, M.D., formerly was a practicing pediatrician, a pioneer neonatologist, Chief Resident at Denver Children's Hospital, VP of the Illinois Hospital Association, and a Joint Commission staff member. At the Illinois Hospital Association, he wrote one of the country's first credentialing manuals in 1977, *Hospital Medical Staff Membership and Delineation of Clinical Privileges: A Practical Guidebook for the Medical Staff, Administration, and Trustees.* Dr. Thompson has over 20 years of experience in areas related to the physician-hospital interface, including credentialing and medical staff bylaws. He formerly served as the American College of Physician Executives' representative on the Joint

Commission's Professional and Technical Advisory Task Force.

Susan I. Toth M.D., is a general surgeon at Meriter-Unity Point Health in Madison, Wisconsin. She is the Chair of Surgery Peer Review, Past President of the Meriter Hospital Medical Staff, and was a Meriter Medical Staff Officer for eight years, during which she reviewed credentialing and privileging for active medical staff.

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Abigail Winkel, M.D., is an Assistant Professor, Vice Chair for Education and Residency Program director in the department of Obstetrics and Gynecology at the New York University School of Medicine. Dr. Winkel oversees credentialing for physicians in the residency and fellowship programs, and reviews privilege request forms for physicians trained at New York University Langone Medical Center.

SUMMARY OF ARGUMENT

In 2013, the State of Texas passed H.B. 2, a law that requires that a physician "performing or inducing an abortion . . . must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that: (A) is located not further than 30 miles from the location at which the abortion is performed or induced; and (B) provides obstetrical or gynecological health care services" (the "admitting privileges requirement"). *See* TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1) and (b) (West Supp. 2014) ("H.B. 2"). The Texas Legislature's stated purpose for enacting the admitting privileges requirement was to raise the standard and quality of care for women seeking abortions and to protect the health and welfare of women seeking abortions. *See* Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013).

Despite its stated purpose, the requirement will make it impossible for qualified physicians in Texas to provide abortion services in most cases. Reserving for others the important question of whether this law is necessary to protect the health and welfare of women, *Amici* will explain how this superficially simple requirement bars qualified physicians from the practice of medicine in outpatient centers where abortion services are provided.

Admitting privileges are not a simple, straightforward evaluation of a physician's competence. Instead, a hospital's decision to grant admitting privileges is the last step in a long process defined by hospital bylaws that evaluates physicians based on several criteria, primarily related to the hospital's interest in the care of hospital *inpatients*. At

each stage of this process, the hospital has the discretion to deny privileges based on a host of factors irrelevant to *outpatient* abortion providers.

In order to secure admitting privileges, a physician first must be recommended and approved for membership on the hospital's medical staff ("credentialing"). Second, the physician must be granted authority to perform specific procedures in the hospital ("privileging"). Both the credentialing and privileging processes require physicians to meet certain pre-qualification criteria before the hospital will even provide the physician with an application for medical staff membership. Most outpatient providers do not ever have the opportunity to apply for credentials and privileges because they are barred at one of the pre-qualification stages.

For example, hospitals may refuse to consider an application because a physician has an economic conflict of interest with the hospital, does not live nearby the hospital, or does not practice within the hospital's mission. Hospitals also deny privileges when a physician cannot demonstrate recent evidence of clinical performance in an inpatient setting. Indeed, there is an inverse relationship between an abortion provider's expertise and her ability to obtain admitting privileges: the more she focuses on outpatient abortion procedures, the less experience she is likely to have with inpatient gynecological procedures and the less likely she is to qualify for inpatient admitting privileges.

As the United States Court of Appeals for the Seventh Circuit held in evaluating the constitutionality of a similar admitting privilege requirement: "[h]ospitals are entitled to demand proof that doctors seeking to work at the

hospital be able to perform the procedures they want to perform there. But, to condition the grant of admitting privileges on being qualified to perform procedures that [ ] abortion doctors never perform is to bar them from performing abortions." *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 917 (7th Cir. 2015). The same is true in Texas. To provide abortions under the Texas law, physicians must have admitting privileges; however, to obtain admitting privileges, they must satisfy criteria that their practice prevents them from meeting.

Even if a physician is able to clear the hurdles necessary to obtain medical staff membership and admitting privileges, that physician still faces the hospital's ongoing review requirements. Once again, these are requirements that outpatient providers likely cannot meet because of the nature of their practice.

The admitting privileges requirement is an insurmountable burden for most abortion providers. The requirement already has dramatically reduced the number of abortion providers in the State of Texas. Prior to the enactment of H.B. 2, 41 licensed facilities provided abortion services across Texas; two years later, only 19 of those facilities remain open. J.A. 1429-1434. The direct effect of the admitting privileges requirement is to bar qualified physicians from performing abortion services, thereby hindering women's access to qualified abortion providers. This effect is in direct contravention of the stated purpose of H.B. 2—to promote women's access to quality care and to promote the health of women seeking abortions. For these reasons, the Texas admitting privileges requirement should be struck down as unconstitutional.

ARGUMENT

In its opinion below, the United States Court of Appeals for the Fifth Circuit assumes that hospitals grant credentials and privileges solely based on physician qualifications and competence. Pet. App. 24a, 25a, 32a. In reality, hospitals increasingly make credentialing and privileging decisions based on an array of factors, many of which are unrelated to outpatient physician competence—including, *inter alia*, hospital admission rates, business realities, and hospital mission.[2] These factors come into play at each stage in the process and pose significant obstacles to outpatient providers.

I. Pre-application requirements and the credentialing process deny most outpatient providers the opportunity to apply for admitting privileges.

To obtain hospital admitting privileges, a physician must first apply for medical staff membership through the credentialing process.[3] If successful, the physician must then apply for specific privileges necessary to admit and treat patients in the hospital, such as ordering tests, performing surgery, and prescribing medication.[4]

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2. *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 Am. J.L. & Med. 173, 179-180 (1996); John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 Buff. L. Rev. 459, 469–471 (2005) (*Beyond the Bylaws*).

3. *See* Appendix A for a chart illustrating the credentialing process.

4. Usually, hospital entities conduct credentialing and privileging contemporaneously. After admission to the medical

"Credentialing" is the process by which a hospital evaluates a physician's application to join the hospital's medical staff. Through the credentialing process, the hospital "assess[es] and confirm[s] the qualifications of a licensed or certified health care practitioner." Trial Ex. P-065, at 6.

Although hospitals enjoy broad discretion in determining the composition of their medical staff, they utilize uniform standards. Most hospitals have adopted the Joint Commission's ("JC") standards because a JC-accredited hospital is deemed to meet the conditions of Medicare participation and is thereby eligible to participate in Medicaid and Medicare. *See generally*, 42 U.S.C. 1395bb; 42 C.F.R. 488.5. Hospitals gain (and maintain) accreditation by demonstrating compliance with JC standards, which are set forth in lengthy manuals that include extensive standards for credentialing and privileging.[5]

A. Pre-Application and Threshold Requirements

The pre-application process begins with a physician requesting the actual application. *See, e.g.*, Trial Ex. P-059 ¶ 3.7.1. The request allows hospitals to ensure that a physician meets its basic or threshold qualifications. Hugh Greeley, *The Greeley Guide to Medical Staff*

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staff, physicians seeking additional privileges only go through the privileging process.

5. *See, e.g.*, JC, *Comprehensive Accreditation Manual for Hospitals 2015 Update 2* (effective Jan. 1, 2016). *Amici* hereinafter cite standards from this manual by number and "element of performance" ("EP"), *e.g.*, "MS.06.01.03, EP 3."

Credentialing 18 (1999) (*Credentialing Guide*). Doctors Hospital at Renaissance ("Doctors Hospital"), one of eight hospitals located within 30 miles of Petitioner Whole Woman's Health's clinic in McAllen (the "McAllen clinic"), requires all requests to be forwarded to the Medical Staff Office, Credentials Committee, Medical Executive Committee, and Governing Body, and Doctors Hospital will only release the application packet once the Governing Body has approved the request. Trial Ex. P-057 ¶ 6.1. Similarly, East El Paso Physician's Medical Center requires a formal written request for an application and will only provide the application if the requesting physician is "deemed eligible to apply." Trial Ex. P-059 ¶ 3.7.1.

One threshold criterion at many Texas hospitals is the signature of a "designated alternate" physician. For example, the eight hospitals located within 30 miles of the McAllen clinic each require, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. J.A. 392, 718. The designated alternate physician must already have admitting privileges at the hospital. *Ibid.*

If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements. J.A. 392, 718. While seeking to provide abortion services at the McAllen clinic, Sherwood C. Lynn, Jr., M.D., Medical Director of Whole Woman's Health in San Antonio, and the three other physicians at the McAllen clinic reached out to numerous physicians with hospital admitting privileges in the McAllen area, but only one was willing to serve as a designated alternate physician for the

physicians. J.A. 718-719, 393. Other physicians expressed fear about retaliation from hospital administrators or revocation of their privileges as the basis for declining to serve as the "designated alternate" physician. *Ibid.* As a result of such concerns, abortion providers often cannot receive the support of a "designated alternate" physician, regardless of their clinical competence, as required by many hospitals' application process. *Ibid.*

This requirement had just such an effect for the McAllen clinic physicians who, because they could locate only one willing designated alternate, were limited to submitting their applications to the one hospital where that designated alternate had admitting privileges. J.A. 718-719, 393. Ultimately, that hospital denied Dr. Lynn and the other physicians the opportunity to apply "based on the recommendation of the hospital's Credentials Committee," although this denial "was **not** based on clinical competence consideration." J.A. 393-394, 604-605, 719-720.

Another common threshold criterion is that the physician maintain a primary residence or office within a certain distance from the hospital. For example, Doctors Hospital requires that members of the medical staff reside within a "reasonable distance" of the hospital, defined as "a travel time to the Hospital not to exceed thirty (30) minutes or from a location within Hidalgo County." Trial Ex. P-057 ¶ 3.4.3.

Based on such threshold requirements, many physicians never have the opportunity to apply for staff membership, much less have their credentialing applications considered. Accordingly, from the start, many physicians will be prevented from offering abortion services due to the admitting privileges requirement.

B. Credentialing Application

If a physician meets the threshold criteria, the hospital will evaluate her application further. Once the hospital receives a complete application, it verifies the application materials with primary sources including specialty boards, employers, schools, and training programs. The hospital also searches the National Practitioner Data Bank, performs background checks, *see* MS.06.01.05, EP 7; MS.06.01.03, Introduction and EP 6., and collects and reviews letters of recommendation from the physician's peers. Trial Ex. P-059 ¶ 3.7.3.10. These letters address issues such as the applicant's clinical competence, personal character, and ability to work collaboratively with others. *See, e.g.*, Trial Ex. P-057 ¶ 6.4.5(h); Trial Ex. P-065, Credentials Manual ¶ 2.2-2(d). Failure to verify all information exposes a hospital to liability for negligent credentialing, so a hospital may not approve an application if a third party fails to submit requested documentation.

After the hospital verifies the application, the file typically goes through a series of individuals and committees, each of which reviews it, gathers additional information, and passes along a recommendation to the next committee. During the review process, committee members may decide to interview an applicant to obtain additional information. If an applicant does not (or cannot) answer questions or if the reviewing committee determines it needs additional information, the application may be declared incomplete. *Credentialing Guide* at 105; *see also* Trial Ex. P-057 ¶ 6.4.1. A committee also may consider confidential reviews of the applicant from staff members or colleagues, which may be tainted by "personal or economic bias." *Credentialing Guide* at 105.

For example, a staff surgeon might present an unfavorable review of an applicant if the surgeon had an anti-abortion bias or thought the applicant might, if admitted to the staff, compete with the surgeon for resources.

Typically, each committee in the review sequence can make one of three final assessments of the application: (1) recommend deferral; (2) give a favorable recommendation; or (3) give a negative recommendation. *See, e.g.*, Trial Ex. P-057 ¶¶ 6.6-6.8. If the final committee in the sequence, the medical executive committee, recommends the application be denied, the hospital will notify the applicant who may, in some cases, be entitled to a hearing to appeal the denial. *Credentialing Guide* at 106.

Following a positive recommendation from the medical executive committee (or after a hearing if required or requested), the recommendations for appointment and/or clinical privileges are submitted to the hospital governing board. The governing board—the corporate management of the hospital—makes final decisions regarding appointment, reappointment, and clinical privileges, based upon review of the committee recommendation. *Credentialing Guide* at 22; MS.06.01.07, EP 8. The board may approve an appointment, reject it, or return the application to the medical staff for further investigation. If the board rejects the application, the applicant may have another opportunity for a hearing or for a formal appeal to the board to reconsider.

Each step in the credentialing process may take one to two months. Overall, it may take upwards of six months *after* the physician's application is deemed complete for the hospital to reach a final decision. During this lengthy

processing, a qualified physician will be barred from providing abortion services. These processing times also would complicate hiring decisions for clinics that must hire abortion providers with admitting privileges.[6]

If a physician obtains staff membership, most hospitals will require her to take "on call" shifts, serve on committees, attend meetings, pay annual dues, and otherwise contribute to the institution's financial and administrative health. Thus, staff appointment comes with significant obligations that are burdensome for a physician who primarily practices elsewhere. A hospital is unlikely to credential or reappoint to the medical staff a physician who cannot or does not fulfill these obligations, regardless of clinical competence. *See infra* Part IV.

II. Physicians who provide abortions in outpatient clinics cannot fulfill hospital requirements for admitting privileges because they do not have an inpatient practice.

H.B. 2's requirement that the physician obtain "active" admitting privileges suggests that the physician must have the ability to provide services to her patient beyond simply admitting the patient to the hospital.

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6. At any point, the hospital may determine that an applicant is ineligible and decline to process her application further. *See, e.g., Credentialing Guide* at 34; Trial Ex. P-057 ¶ 6.4. Because a determination of "ineligibility" is not a denial based on demonstrated incompetence or unprofessional conduct, it does not trigger the applicant's right to formal due process, including a hearing or an appeal. Trial Ex. P-057 ¶ 13.3.

Once a hospital appoints a physician to the medical staff, the hospital then assesses her request for privileges.[7] *Credentialing Guide* at 6-7. Clinical privileges are granted to physicians so that they can, *inter alia*, "render specific professional, diagnostic, therapeutic, medical, dental or surgical services." Trial Ex. P-064 at 2; *see also Credentialing Guide* at 181. Admitting privileges constitute one particular privilege, allowing a physician to place a patient in the hospital under that physician's care. However, a physician is never granted just "admitting privileges" because she must be authorized to provide some specific type of clinical care to that patient upon the patient's admission. *See generally* MS.06.01.05.

As with the credentialing process, the privileging process is set forth in medical staff bylaws and policies. *See* MS.01.01.01, EP 14; MS.06.01.05, Introduction. Unlike a grant of medical staff membership, privileging grants "applicant-specific delineated privileges," defining exactly which procedures and clinical activities the physician is permitted to perform in the hospital. This means hospitals must verify that applicants have demonstrated current competence in the procedures and activities for which they seek privileges. MS.06.01.05, Introduction; *Credentialing Guide* at 181.

A. Experience with Inpatient Treatment

More than "90 percent of all abortions performed in the U.S. are performed in the outpatient setting." J.A. 253. In Texas, 96 percent of abortions performed in 2010, for

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7. *See* Appendix B for a chart illustrating the privileging process.

example, were performed in an outpatient setting. J.A. 263. While abortion providers easily could demonstrate competency in the outpatient procedures they regularly perform, they may be unable to demonstrate current competence in all of the inpatient procedures that the hospitals demand, which would prevent them from obtaining privileges, including admitting privileges. As Judge Posner concluded in the Seventh Circuit's opinion, the reason abortion providers could not obtain admitting privileges "is that almost all of their practice consists of performing abortions and they therefore lack recent experience in performing inpatient medical procedures for which hospitals would grant admitting privileges." *Planned Parenthood of Wisconsin*, 806 F.3d at 916.

Physicians applying for hospital admitting privileges generally are required to demonstrate substantial recent experience treating patients in inpatient settings. While hospitals traditionally granted privileges procedure by procedure, based on an individual physician's experience and expertise, most hospitals have responded to the increasing complexity of privileging with a "core privileging approach," which essentially groups multiple privileges for related procedures and activities into a single "core" privilege. These broader sets of "core" privileges—for example, in obstetrics, gynecology, or family medicine—encompass the "clinical activities that any appropriately trained physician [in that specialty] would be competent to perform." *Credentialing Guide* at 183. Foundation Surgical Hospital of El Paso ("Foundation"), for example, offers core privileges in family medicine, a set of privileges that includes procedures such as suturing and repairing lacerations, interpreting electrocardiograms, and treating burns. Trial Ex. P-062. Thus, rather than tailoring

the privileges to be granted to the specific provider's experience, the hospital essentially requires each provider to be able to demonstrate competence in a more extensive list of skills and procedures. Core privileging erects yet another obstacle for many outpatient providers who rarely, if ever, treat patients in a hospital and may have little recent practice in many of the core procedures not applicable to their practice.

Hospitals also often require applicants to provide clinical *data*, particularly data derived from inpatient hospital care, to demonstrate their competence. *See* MS.06.01.03, Introduction and Rationale; MS.06.01.05. These hospitals will not even consider privilege requests unless applicants provide "clinical data demonstrating the number and type(s) of clinical activities . . . performed." *Credentialing Guide* at 181-82; *see also* MS.06.01.05, EP 10. Foundation's application for core privileges in family medicine requires that initial applicants be able to show that they have provided *inpatient* care for at least 24 patients in the previous 12 months as either the attending physician or senior resident. Trial Ex. P-062. Likewise, at Rio Grande Regional Hospital, physicians seeking privileges in obstetrics and gynecology must be able to demonstrate the completion of at least 50 deliveries and 25 gynecological surgeries or successful completion of a qualifying residency, fellowship, clinical fellowship, or research. Trial Ex. P-076, OB/GYN Privileges request form. For physicians who work primarily in outpatient settings, and spend little if any time in hospitals, these requirements are impossible to meet.

For example, over the last ten years, Nova Health Systems d/b/a Reproductive Service's clinic in El Paso

(the "El Paso clinic") performed over 17,000 abortion procedures, and not a single patient was transferred to a hospital for emergency treatment, much less admitted to a hospital. J.A. 730. Similarly, the McAllen clinic provided abortion services to over 14,000 patients during the ten years it was in operation, and only two patients required transfer to a hospital. J.A. 717. Given the nature of their outpatient practices and the extraordinarily rare need for inpatient care for their patients, abortion providers generally will be unable to meet hospitals' inpatient clinical data requirements for admitting privileges.

Even if a hospital allows an abortion provider to formally apply for privileges, the physician must meet additional extensive criteria including licensure, training, professional experience, and peer recommendations. MS.06.01.05, Introduction, EP 2. Most significantly, the physician must demonstrate appropriate training and "**recent** direct or indirect experience" related to the privileges requested." *Credentialing Guide* at 183 (emphasis added). Providence Memorial Hospital, for example, mandates that a decision to grant privileges take into account the physician's "performance of a sufficient number of procedures to demonstrate and maintain proficiency." Trial Ex. P-075 at ¶ 9.1.3. While abortion providers may perform sufficient *outpatient* procedures to demonstrate their proficiency in those particular procedures, they are unlikely to demonstrate the requisite number of *inpatient* procedures required for privileging given the outpatient nature of their practices. Indeed, it is impossible for a physician who practices only outpatient medicine to show that she has performed any recent procedures on an inpatient basis; it is therefore highly unlikely she will qualify for admitting privileges.

B. Specialty-Related Requirements

As with requests for medical staff membership, hospitals regularly reject privileging requests on threshold eligibility grounds without ever formally considering the application. One type of eligibility requirement is a requirement that physicians hold specific board certifications to perform particular procedures, thus barring physicians with other specialties from even applying for the applicable privilege. For example, the hospital may require board certification in obstetrics and gynecology in order to be granted the privilege to perform obstetrical or gynecological procedures, even though many family physicians and surgeons have training that makes them competent in these procedures. Similarly, some hospitals require a physician to have completed a residency in the particular specialty for which she seeks clinical privileges. *See, e.g.*, Trial Ex. P-059 at ¶ 3.1.3.

Pamela Richter, D.O., who served as Medical Director for the El Paso clinic for over 20 years, sought but was denied admitting privileges at Foundation. J.A. 726, 730. Dr. Richter is a board-eligible family medicine physician licensed to practice medicine in Texas. In addition to serving as Medical Director and the only physician performing abortion services at the El Paso clinic, Dr. Richter also provides gynecological and general medical care as a staff physician at a state supported and operated residential facility in El Paso. J.A. 727-728, 731.

Although Dr. Richter was board-certified in family medicine from 1990 to 2009, she did not seek recertification after 2009 because board certification was unnecessary for her practice. J.A. 727. As a result, Dr. Richter was

determined by Foundation not to meet the threshold criteria and her application for admitting privileges at Foundation was denied because she did not "meet the requirement [sic] for successfully completing a residency in the field of specialty for which clinical privileges are required." J.A. 729-730. The decision ignored Dr. Richter's substantial experience practicing gynecology and her previous board certification. *Ibid.*

In fact, Foundation's requirements for family medicine privileges did not require completion of a family medicine residency if the physician demonstrated "active participation in the examination process leading to [board] certification in family medicine . . . ." Trial Ex. P-062. As such, Dr. Richter did not actually have to meet the family medicine residency requirements because she was registered to take the next available family medicine board examination. J.A. 729-30. This application of Foundation's requirements to Dr. Richter's application illustrates the subjective nature of privileging and the risk that hospitals will use compliance with their bylaws as an excuse for denying privileges to qualified providers.

Dr. Richter also sought admitting privileges at Las Palmas del Sol ("Las Palmas") and University Medical Center ("UMC"). J.A. 729. She was informed that her application would not be considered unless she provided documentation of current board-certification. *Ibid.*

III. The discretionary nature of the credentialing and privileging process creates an opportunity to deny abortion providers admitting privileges on grounds other than clinical competence.

Historically, hospital boards, relying on the recommendations made by the hospital's medical staff, mostly "rubber-stamped" physician applications for hospital privileges. However, "the board today plays a constant, active role in . . . [the] credentialing process," *Credentialing Guide* at 22-23, and frequently retains the discretionary power to make privileging decisions on bases unrelated to physician competence. Hospital bylaws intended to protect the economic well-being or mission of the hospital may be used by reviewing committees to deny abortion providers admitting privileges. These provisions, coupled with the general ambiguity and subjective nature of the credentialing and privileging processes, thus provide hospitals an easy pretext for withholding privileges from abortion providers.

A. Denial Based on Economic Impact

One such pretext for rejecting applicants is the practice of economic credentialing, which reflects the significant impact credentialing decisions have on hospital finances. Robin Locke Nagele, et al., *Economic Credentialing* ix (2004). Traditional sources of hospital revenue have been threatened by the increase in ambulatory surgical centers, "specialty" hospitals, and physicians offering in their own offices or facilities expensive diagnostic tests (like endoscopies or MRIs). Hospitals must work to keep "medical staffs committed to practicing in the inpatient setting while curbing the revenue drain associated with their outpatient entrepreneurial activities." *Id.* at xiii.

In response to this "revenue drain," some hospital boards have begun to "assess[] (as a qualifying factor) the financial impact of accepting a physician onto a hospital's medical staff." *Id.* at xviii; *see also Beyond the Bylaws* at 470-474; Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members*, 36 J. Health L. 247, 252 (*New Econ. Credentialing*). Economic credentialing takes many forms, including "medical staff development plans," which specify "optimal formula[s]" for staff numbers after an analysis of market conditions, infrastructure, resources, usage, staff profiles, and referral patterns. *Economic Credentialing* at 31-34; *see also, e.g.*, Trial Exs. P-065 ¶ 2.1.2, P-057 ¶ 10.4. These plans inform staff recruitment, including whether or not particular departments will have a "closed staff," whereby the hospital decides not to accept additional applications for privileges in a particular department. *Beyond the Bylaws* at 476-477.

Some hospitals also ask physicians for "individual practice plans," which detail the applicant's specialization, need for resources, anticipated time at the hospital, expectations for admissions and referrals, financial relationships with rival entities, and willingness to support the hospital mission (for example, treating uninsured patients). *Economic Credentialing* at 47; Trial Ex. P-057 ¶ 10.4. If the board decides that the physician's plan is inconsistent with hospital goals, the plan alone may disqualify the applicant.

Exclusive contracts are another common form of economic credentialing. Under these contracts, hospitals agree that a single private medical group will be the exclusive provider of particular medical services at the

hospital. *Economic Credentialing* at 51; *Beyond the Bylaws* at 475-476. Only physicians who are members of that practice group may apply for privileges to provide the services subject to the exclusive contract. Similarly, if a member physician leaves the group, she usually will lose her privileges and staff membership.

More contentious forms of economic credentialing include conflict-of-interest policies that restrict a physician's work with competitors. For example, a general hospital may deny membership to a physician who also practices at a specialty hospital in the same area because the physician could create a "dire situation" by cherry-picking the most profitable patients for treatment at the specialty hospital and treating only low- or no-pay patients at the general hospital. *Economic Credentialing* at xiii; *Beyond the Bylaws* at 484. Courts continue to wrestle with the legality of such conflict-of-interest policies. *Economic Credentialing* at 89-109; *New Econ. Credentialing* at 253-284; *Beyond the Bylaws* at 482-486. The fact that hospitals use these strategies—despite the potential liability—underscores how important fiscal considerations are in hospital credentialing.

Many Texas hospitals practice one or another form of economic credentialing. For example, South Texas Health System may decline to provide or review applications for staff membership or particular privileges based on whether they are (1) "within the scope of services, capacity, capabilities, and business plan of the hospital"; (2) subject to an exclusive contract; or (3) within the requirements or limitations in the Medical Staff development plan, which is formulated based on patient care needs in the population served by the hospital. *See, e.g.*, Trial Exs. P-065 ¶ 2.1.2,

P-078, Art. IV, § 2(A). Doctors Hospital will consider the hospital's need for certain services before granting privileges, Trial Ex. P-057 ¶ 10.4, and several hospitals, including East El Paso Physicians' Medical Center, Rio Grande Regional Hospital, will consider the hospital's ability to provide support and facilities for the services for which the physician seeks privileges. Trial Exs. P-059 ¶ 5.2.4, P-076 ¶ 3.2.

Hospitals that practice economic credentialing may have no reason to grant staff membership or admitting privileges to outpatient physicians providing abortion services. These physicians likely will not admit any patients to the hospitals because the rate of complications is extraordinarily low for abortions. *See Planned Parenthood of Wisconsin*, 806 F.3d at 912-13. Further, outpatient providers who likely will spend little time at the hospital are less likely to help with committee work, backup coverage, or resident training. An outpatient abortion provider offers no clear benefit to a hospital; instead, she may pose significant expense in the patients referred, time and resources of credentialing, and stigma of association with an abortion provider.

B. Denial Based on Hospital Mission

Hospitals also may deny or refuse to consider an application if it appears that the physician cannot support the hospital's "mission." For example, an academic medical center may require staff members to teach or do research. South Texas Health System requires applicants to demonstrate that they will "contribute to meeting the mission of STHS." Trial Ex. P-065 at ¶ 2.1.1.

Other hospitals, particularly those with religious affiliations, require physicians to comply with religious and ethical directives that counsel against "scandal in any association with abortion providers." *See, e.g.*, United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 26 (5th ed. 2009). Although the so-called "Church Amendments," enacted by Congress in the 1970s, prohibit these hospitals from discriminating against physicians because of their involvement with abortion procedures, 42 U.S.C. 300a-7(c)(1), the ease with which hospitals can simply decline to consider applications on other permissible grounds strongly suggests that religiously affiliated hospitals will deny admitting privileges to abortion providers.

Secular hospitals also may be unwilling to subject themselves to the negative attention that sometimes follows abortion practitioners, even though Texas law mandates that "[a] hospital or health care facility may not discriminate against a physician, nurse, staff member, or employee because of the person's willingness to participate in an abortion procedure at another facility." Tex. Occ. Code Ann. § 103.002(b) (1999). For example, although Foundation claimed it was discontinuing Dr. Richter's temporary privileges and denying her application for privileges because of its family medicine residency requirements, Foundation took these actions only after it became aware that Dr. Richter provided abortion services. Trial Ex. P-046; J.A. 729-730. In fact, the hospital's C.E.O. candidly told a Texas Department of State Health Services investigator that the hospital had combed through its own bylaws for a reason to deny Dr. Richter's application once it learned about her practice.

Trial Ex. P-046 ("He stated the facility was not aware that Dr. Richter provided abortion services. He stated after finding out she provided these services that the facility looked at the bylaws and application to see if there was a reason to deny privileges to Dr. Richter."); J.A. 730.

Similarly, in another Texas case involving attempts by abortion providers to obtain admitting privileges, *Robinson v. UGHS Dallas Hospitals, Inc.*, No. DC-14-04101 (Tex. Dist. Ct., consent order approving settlement, June 9, 2014),[8] the bylaws of University General Health System Dallas Hospitals, Inc. ("UGHD") included a provision on "disruptive behavior," defined as, *inter alia*, "[p]ersonal conduct . . . that adversely impacts, or potentially may impact, the operation of the Hospital . . . ." Pet., *Robinson*, ¶ 37 (filed April 17, 2014). Two gynecologists with over three decades of experience in reproductive health and abortion services initially were granted admitting privileges at UGHD primarily related to their gynecological practices and in accordance with the requirements of H.B. 2. *Id.* ¶¶ 4-5. After obtaining privileges, the physicians continued performing abortions at facilities unrelated to UGHD. The hospital reversed its privileging decisions three months later, stating:

> Your privileges have been revoked at [UGHD] by the Medical Executive Committee . . . based on the following: . . . It has come to our attention that you perform "voluntary interruption of

8. Available through Dallas County & District Courts Case Information, *at* courts.dallascounty.org (follow "Civil District Case Information" hyperlink; then search by Case Number "DC-14-04101") (last visited Dec. 30, 2015).

> pregnancies" as a regular part of your medical practice. . . UGHD has determined that your practice of performing these procedures is disruptive to the business and reputation of UGHD and, therefore, violates UGHD's bylaws as "disruptive behavior" . . . because, among other things, the practice creates significant exposure and damages to UGHD's reputation within the community. UGHD cannot afford to defend your privileges in light of this practice.

Pet., *Robinson*, Ex. A.

In response, the physicians sought, *inter alia*, injunctive relief and immediate reinstatement of their admitting privileges. Pet., *Robinson*, at 19. The court issued a temporary restraining order requiring UGHD to reinstate the physicians' admitting privileges because the revocation likely violated Texas' unlawful discrimination law; it later issued a permanent injunction following a settlement among the parties. Nonetheless, the physicians' experience illustrates how hospitals may employ discretionary bylaw provisions to deny admitting privileges to abortion providers, thus barring them from performing abortions under H.B. 2.

IV. An outpatient provider who is granted admitting privileges likely will lose them due to ongoing review requirements.

If a hospital ultimately does grant a physician staff admitting privileges, it initially will review the exercise of the privilege at the hospital to confirm the competency of the physician. This initial review of clinical

competence in a newly granted privilege is known as "Focused Professional Practice Evaluation," or FPPE. *See generally* MS.08.01.01; Introductions to MS.06.01.01, MS.06.01.05. In addition to review of medical records and discussions with other staff members about the physician's performance, FPPE usually includes direct observation of the physician's medical techniques, or "proctoring." *See, e.g.*, Trial Ex. P-075 ¶ 8.6. The physician usually is required to conduct a required number of proctored procedures in order to maintain privileges.

At many hospitals, including those in Texas, a physician will be deemed to have voluntarily resigned her privileges if she fails to complete the required number of proctored cases. Trial Exs. P-075 ¶ 8.6, P-076 ¶¶ 3.14.1, 3.14.4.1. Thus, even if a primarily outpatient abortion provider were able to obtain admitting privileges, she would have a credible fear of losing them in the near future as she would have little occasion or need to treat a patient at the hospital. As discussed *supra*, during the last ten years, the McAllen clinic only required transfer to a hospital for two patients (out of 14,000 abortions), J.A. 717, while the El Paso clinic required no transfers, J.A. 730. These numbers demonstrate the practical impossibility of maintaining admitting privileges as the physicians would be unable to complete the requisite number of proctored cases.

Even if a practitioner successfully completes the FPPE process and graduates to more permanent status at the hospital, she likely would be subject to ongoing monitoring requirements. These relatively new requirements expand "the credentialing and privileging process" from "a procedural, cyclical process in which practitioners are

evaluated when privileges are initially granted, and every two years thereafter," to an "Ongoing Professional Practice Evaluation" ("OPPE"), which re-evaluates the physician on a more or less continual basis. MS.06.01.01, Introduction; *see generally* MS.08.01.03, When a physician seeks to renew her privileges, the hospital uses OPPE data as evidence of the physician's current competence in the procedures for which she has privileges. Without sufficient OPPE data, a physician will be unable to renew her privileges. At Rio Grande Regional Hospital, for example, physicians must have sufficient patient contact to "enable the assessment of current clinical judgment and competence for the privileges requested." Trial Ex. P-076 ¶ 3.10.5. An OPPE for a physician with little or no hospital practice essentially would be impossible.

Furthermore, "[h]ospitals generally require that a doctor, to maintain his admitting privileges, be responsible for admitting a specified minimum number of patients annually." *Planned Parenthood of Wisconsin*, 806 F.3d at 917. In some cases, these admissions all must occur at the privileging hospital. Doctors Hospital, for example, generally only allows physicians on active staff to admit patients, but also requires that such physicians use the hospital for "at least 24 major procedures annually," with limited exceptions. Trial Ex. P-057 ¶¶ 3.5.15, 4.1, 4.2. However, "[b]ecause of the very low rate of complications from abortions that require hospitalization, the required quotas may be difficult to meet" for outpatient abortion providers. *Planned Parenthood of Wisconsin*, 806 F.3d at 917. Again, the McAllen and El Paso clinics performed more than 31,000 abortions but collectively required transfer—not necessarily even admission—of only two patients over the past 10 years. J.A. 717, 730. Because

of their infrequent need to treat patients in the hospital, abortion physicians who manage to secure admitting privileges may well lose them during the re-privileging process. *See, e.g.*, Trial Ex. P-076 ¶ 3.10.5.

This requirement would impose a further barrier on the ability of abortion providers to maintain clinical privileges because of the nature of abortion complications. In the extremely rare case of an abortion-related complication, the patient frequently already has been discharged from the clinic and returned home (sometimes over 150 to 200 miles from the clinic). J.A. 382-383, 278. The complications that follow a medical abortion likely never would occur while the patient is at the clinic because the abortifacient medications take time to exert their effects. *Ibid.* In the unusual instance where a patient experienced heavy bleeding requiring additional treatment, this symptom likely would occur one to three weeks following the abortion. *Ibid.* As a result, the patient may or may not be in the vicinity of the clinic, and the patient may or may not elect to seek treatment at the hospital where the outpatient abortion provider has admitting privileges. *Ibid.* Given the sporadic nature of any required follow-up care, a physician's ability to include this as clinical treatment data at the privileging hospital is even less likely.

The JC acknowledges that the OPPE practice does "not fully address the issue of the low or no volume practitioner" in that such physicians will have very limited data to review.[9] At some hospitals, such as Rio Grande

9. *JC FAQ "Using Data from Outside Organizations to Accomplish the Ongoing Professional Practice Evaluation/Low*

Regional Hospital, physicians who have insufficient patient volume to serve on the hospital's active staff may obtain "Refer and Follow" or "Refer Only" privileges; they are not permitted to obtain admitting privileges. Trial Ex. P-076, Qualifications for Privileges in Obstetrics and Gynecology at 1. These limited privileges would not meet the requirements of H.B. 2. While some other hospitals offer courtesy privileges or staff membership for low volume providers—allowing them to exercise clinical privileges including admitting privileges—courtesy privileges generally only are available to physicians with active privileges at another hospital. At Mission Regional Medical Center, for instance, physicians may qualify for courtesy staff membership with eleven or fewer patient encounters, but to do so physicians must be on active staff at another hospital. Trial Ex. P-064 ¶ 4.3. Given the difficulty of obtaining admitting privileges at just a single hospital, this alternative option would be virtually impossible to pursue or fulfill. Consequently, this is yet another obstacle to Texas-based abortion providers obtaining admitting privileges.

Requirements for minimum levels of inpatient patient encounters have been a concern for some of the petitioners in this case. For instance, Marilyn Eldridge, President of Reproductive Services and the El Paso clinic, testified that even if Dr. Richter had obtained admitting privileges, Ms. Eldridge worried that Dr. Richter would not be able to maintain the privileges "because she [would] not be able to admit the requisite number of patients per year

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Volume Practitioners" (last updated March 23, 2010), http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=311&StandardsFAQChapterId=74.

to the hospital." J.A. 730. Both the McAllen and El Paso clinics serve as examples of how the admitting privileges requirement will bar qualified physicians from performing abortion services for reasons completely unrelated to their medical competence.

CONCLUSION

To obtain active admitting privileges at a hospital, as required by H.B. 2, a physician must navigate a labyrinthine credentialing and privileging process that evaluates physicians based on many factors unrelated to clinical competence. The intricate and subjective process leaves abortion providers—generally outpatient physicians—in a "Catch-22." The more experienced the physician is in outpatient abortion services, the less likely she will be able to demonstrate the inpatient experience that is required to obtain admitting privileges. H.B. 2 imposes a baseless, costly exercise upon hospitals and physicians that fails to assure quality care for women. If upheld, the admitting privileges requirement will unnecessarily burden hospitals and will bar many qualified physicians from providing abortions, thereby limiting access to those services.

For the foregoing reasons, the judgment of the Fifth Circuit should be reversed.

Respectfully submitted,

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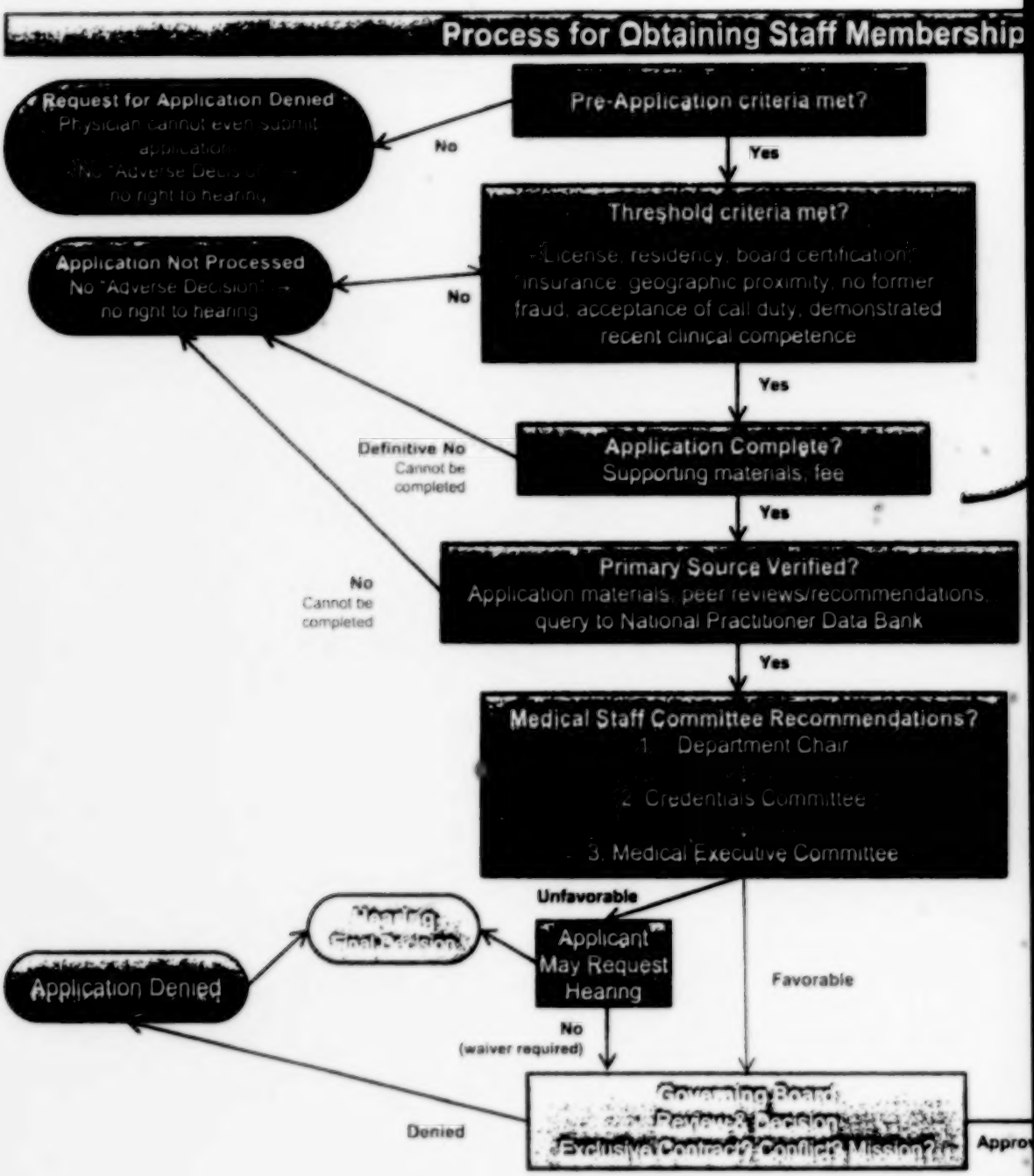
December 30, 2015

APPENDIX

APPENDIX A — PROCESS FOR OBTAINING STAFF MEMBERSHIP

FOLDOUT


Process for Obtaining Staff Membership
Pre-Application criteria met?
Request for Application Denied
Physician cannot even submit application
No "Adverse Decision" → no right to hearing
No
Yes
Threshold criteria met?
License, residency, board certification, insurance, geographic proximity, no former fraud, acceptance of call duty, demonstrated recent clinical competence
Application Not Processed
No "Adverse Decision" → no right to hearing
No
Yes
Definitive No
Cannot be completed
Application Complete?
Supporting materials, fee
Yes
No
Cannot be completed
Primary Source Verified?
Application materials, peer reviews/recommendations, query to National Practitioner Data Bank
Yes
Medical Staff Committee Recommendations?
1. Department Chair
2. Credentials Committee
3. Medical Executive Committee
Unfavorable
Favorable
Applicant May Request Hearing
Application Denied
No
(waiver required)
Denied
Governing Board
Approv

APPENDIX B — PROCESS FOR OBTAINING PRIVILEGES

FOLDOUT

Process for Obtaining Privileges